AGUAYO CHIROPRACTIC & Wellness

DR. JASON P AGUAYO DC

Patient Intake Form

Patient Name: _____ **Date:** ____/____/____

Welcome to our office! To help us serve you better please fill out the following information. Your responses are important to help us better understand the health issues you face and ensure the best possible treatment.

Please check any of the following that give you difficulty or you had had recently

☐Headaches	☐Fainting	☐Shortness of breath	☐Numb legs/feet
☐Shooting head pains	☐Loss of balance	☐Mid-back pain	☐Constipation
☐Sinus trouble	☐Ringing in ears	☐Heart attack	☐Kidney trouble
☐Loss of smell	☐Blurred vision	☐Low blood pressure	☐Menstrual cramps
☐Allergies	☐Lights bother eyes	☐High blood pressure	☐Menstrual irregularity
☐Hay fever	☐Neck pain	☐Anemia	☐Diabetes
☐Asthma	☐Muscle spasms in neck	☐Nerves/nervousness	☐Painful joints
☐Inflammation of throat	☐Shldr/arm tightness	☐Inner tension	☐Swollen joints
☐Thyroid trouble	☐Shldr/arm pain	☐Irritability	☐Pins & needles in leg
☐Facial twitch	☐Pins & needles in arms	☐Gall bladder trouble	☐Swollen ankles
☐Loss of memory	☐Pins & needles in hands	☐Indigestion	☐Cold Feet
☐Fatigue	☐Cold Hands	☐Intestinal gas	☐Pain in legs/feet
☐Depression	☐Numbness in arms/hands	☐Low back pain	☐Hip pain
☐Spinal curvature	☐Prostate trouble	☐Stroke	☐Jaw pain/TMJ
☐Chest pain	☐Bed wetting	☐Arthritis	☐Ulcers
☐Ear ache	☐Cancer	☐Seizures	☐Frequent urination

Are you pregnant? ☐Yes ☐No If yes, how many months? _____

Current Health:

How do you describe your current health: _____

How would you describe your family's health: _____

Describe your (please circle): Vision: Good/Fair/Poor Hearing: Good/Fair/Poor Coordination: Good/Fair/Poor

Do you use any of the following (please circle): Tobacco Alcohol Coffee Soda Milk

Level of stress in your life (circle one): Mild / Moderate / Extreme Rating of stress: 1 2 3 4 5 6 7 8 9 10

Please list any medication you are currently taking and why: _____

_____

_____

Do you have any other health issues or concerns that our staff should be made aware of?

_____

_____

Family History: please check and indicate which relative(s)

☐Alcoholism	☐Bleed easily	☐Epilepsy	☐Multiple sclerosis
☐Anemia	☐Cancer	☐Glaucoma	☐Osteoporosis
☐Arteriosclerosis	☐Diabetes type 1	☐Heart disease	☐Stroke
☐Arthritis	☐Diabetes type 2	☐High blood pressure	☐ Thyroid disease
☐Asthma	☐Emphysema	☐High cholesterol	

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Give a brief detailed description of the problem you are currently experiencing: _____

_____

_____

How long have you had this condition? _____ Is it getting worse? □ Yes □ No

What seemed to be the initial cause (be specific): _____

Please circle how frequent the complaint is present: Occasional Intermittent Frequent Constant

Please rate your pain

Neck Pain
0 1 2 3 4 5 6 7 8 9 10

Shoulder, Arm Pain
0 1 2 3 4 5 6 7 8 9 10

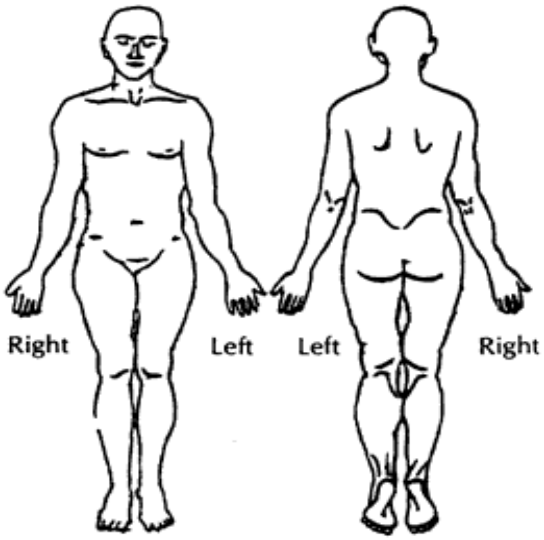
Upper, Mid or Both Back Pain
0 1 2 3 4 5 6 7 8 9 10

Low Back Pain
0 1 2 3 4 5 6 7 8 9 10

Hip, Leg Pain
0 1 2 3 4 5 6 7 8 9 10

Other Pain_____
0 1 2 3 4 5 6 7 8 9 10

Please mark your area(s) of pain on the figures below



Past Health History

Have you.....	Yes	No	If yes, explain briefly
been hospitalized in the last 5 years?	☐	☐	_____
had any mental disorders?	☐	☐	_____
had any broken bones?	☐	☐	_____
had any strains or sprains?	☐	☐	_____
ever used orthotics?	☐	☐	_____
Do you take minerals, herbs or vitamins?	☐	☐	_____

How is most of your day spent? ☐ standing, ☐ sitting, ☐ other: _____

How old is your mattress? _____

When was your last physical exam? _____

Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

0 =no effect 1=mild effect 2=moderate effect 3=severe effect

Sitting	0	1	2	3	Caring for family	0	1	2	3
Rising out of chair	0	1	2	3	Grocery shopping	0	1	2	3
Standing	0	1	2	3	Household chores	0	1	2	3
Walking	0	1	2	3	Lifting objects	0	1	2	3
Lying down	0	1	2	3	Reaching overhead	0	1	2	3
Bending over	0	1	2	3	Showering/bathing	0	1	2	3
Climbing stairs	0	1	2	3	Dressing myself	0	1	2	3
Using a computer	0	1	2	3	Getting to sleep	0	1	2	3
Getting in/out of car	0	1	2	3	Staying asleep	0	1	2	3
Love life	0	1	2	3	Yard work	0	1	2	3
Exercising	0	1	2	3	Driving a car	0	1	2	3

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

____I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

____I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period ____/____/____

____I grant permission to be called or receive a text message to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

____I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

____To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signed: _____ **Date:** ____/____/____